Martinsburg Eye Associates, PLLC

Patient Information

Name Last:_____First:_____Middle:_____

Date Of Birth:_____Marital Status:_____

Address:_____

City:_____State:_____Zip Code:_____

Email:_____

Cell Number:_____Other Phone Number_____

Occupation:_____Employer:_____

Emergency Contact:_____Phone Number:_____

If Minor Parent's Name:_____

Name of Family Physician:_____

Referring Doctor:_____

Insurance Information

Insurance Name:_____

Name of Subscriber: ___Self ___Other:_____Date of Birth:_____

Lifetime Authorization and Assignment of Benefits

I hereby authorize the physicians and staff of Martinsburg Eye Associates, PLLC to perform such treatments to me as may be prescribed by my attending physician during any and all my visits to Martinsburg Eye Associates, PLLC. I understand that I am financially responsible for all charges arising from services rendered to me by Martinsburg Eye Associates, PLLC. I hereby authorize Martinsburg Eye Associates, PLLC to file on any and all insurance for any charges that I incur. I request that all payments from any of these insurance's be mailed directly to Martinsburg Eye Associates, PLLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any insurance company, any information needed to determine these benefits or the benefits payable for related services. **There is an additional charge of $30 for Refraction.**

I acknowledge that I received a copy of Martinsburg Eye Associates, PLLC Notice of Privacy Practices

Patient's Signature:_____Date:_____

Name_____ Date _____

Date of **Birth** _____ Date of last **eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? ☐ YES ☐ NO If YES, list the medications: _____

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

List any **surgeries** you have had (Including eye surgeries): _____

_____

Do you currently have any problems in the following areas?

Eyes	Yes	No	**Females**	Yes	No
Poor Vision			Pregnant/Nursing?		
Eye Pain			**Muscles/Bones/Joints**		
Tearing			Joint Pain		
General/Constitutional			Swelling		
Fever			Arthritis		
Weight Gain/Loss			**Skin**		
MRSA infection			Rash		
Cardiovascular			Growths		
High BP			**Neurologic**		
Heart Problems			Headache		
Respiratory			Seizures		
Congestion			Paralysis		
Wheezing			**Psychiatric**		
Shortness of Breath			Anxiety		
Gastrointestinal			Depression		
Diarrhea/Constipation			**Endocrine**		
Ulcers			Diabetes		
Hernia			Thyroid		
Genital/Kidney/Bladder			**Blood/Lymphatic**		
Painful Urination			Bleeding Disorders		
Blood in urine			High Cholesterol		

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases? (Check all that apply) YES____ NO____ UNKNOWN____

Blindness___ , Cataract___, Glaucoma___, Diabetes___, Hypertension___, Heart Disease___, Stroke___, Cancer___, Thyroid Disease___, Arthritis___ Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES____ NO____

Are you pregnant or nursing?.....YES____ NO____

Do you drink alcohol?..... YES____ NO____ If YES, how much? _____

Do you smoke?..... YES____ NO____ If YES, how much? _____ How many years? _____